Abstract: Oral tonsils (ectopic oral tonsillar tissue) are rarely remarked upon. They may cause diagnostic confusion, especially when found in the floor of the mouth. We report here two cases of patients presenting because of oral tonsillar tissue, to remind colleagues of its occurrence and the need to consider the lesion in the differential diagnosis of soft tissue nodules of the oral cavity.

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Clinical Relevance: Oral tonsils on the floor of the mouth are little known and cause diagnostic confusion.

Waldeyer’s ring comprises aggregates of lymphoid tissue in the oropharynx including the adenoids on the posterior pharyngeal wall, the tonsils in the fauces on the lateral oropharyngeal walls and the lingual tonsils occurring on the lateral borders of the posterior part of the tongue. Lingual tonsils are well known and are usually asymptomatic, although they may become enlarged and tender secondary to mechanical irritation or local infection. The occurrence of ectopic tonsillar tissue elsewhere in the oral cavity (oral tonsils), however, is less well known. When such lesions are small and not inflamed they do not attract attention. However, when enlarged and erythematous, or undergoing cystic change due to keratin plugging, they may become noticed by the patient or the dentist. A review of the University Dental Hospital of Manchester Oral Pathology database indicates that approximately one biopsy sample of an oral tonsil is received each year, the great majority having been removed from the floor of the mouth. As examples, we report here two patients referred for investigation because of the presence of such lesions.

CASE REPORTS

Case 1
A 48-year-old male was referred by his general dental practitioner complaining of having ‘small lumps’ on the floor of his mouth. These swellings were asymptomatic and had only been noticed by the patient’s general dental practitioner at a routine examination, three months previously. The patient had been unaware of the lesions prior to this but, on attendance, admitted he was worried regarding the nature of these lesions.

The patient was asthmatic, but was otherwise well. He had no known allergies and was on no medication.

Clinical examination revealed the presence of three small, red, circular lesions in the mucosa of the floor of...
the mouth (Figure 1). The lesions were uniform in colour, raised on the mucosa and approximately 3 mm in diameter. No tenderness could be elicited from them.

An excision biopsy of one of the three lesions was subsequently performed. Histologically, sections were found to show normal oral mucosa in which there was an aggregation of lymphoid tissue within the lamina propria (Figure 2). Several well-defined lymphoid follicles were present. The features were consistent with those of tonsillar tissue.

Post-operatively, the biopsy site healed well with no complications and no evidence of recurrence. The patient was reassured as to the benign nature of the lesions.

**Case 2**

A 41-year-old female was referred by her general dental practitioner regarding a white nodule on the left undersurface of the tongue. The lesion was asymptomatic and had been noticed by the patient two years previously. The patient was well and on no medication.

Clinical examination revealed a 4 mm diameter, white mucosal nodule just to the left of the frenum of the ventral surface of the tongue. The lesion was soft to palpation and non-tender.

An excisional biopsy of the lesion was performed. The histological appearance was of oral mucosa in which there was a focus of lymphoid tissue including follicles with well-formed germinal centres. A cystic lesion lined by stratified squamous epithelium was also seen in close relationship, the cystic lesion being filled with keratinous debris (Figure 3). The features were consistent with keratin plugging in an oral tonsil.

Post-operative recovery was uneventful and the patient was reassured as to the benign nature of the lesion.

**DISCUSSION**

Ectopic tonsillar tissue has previously been documented in the orbit\(^1\) and nasal septum.\(^3\) Its presence in the mouth has also been noted but it remains a little known and seldom recognized lesion. In a study of 503 male subjects examined specifically for oral tonsillar tissue, 21% were thought to have tonsillar tissue in the soft palate, 5% on the ventral surface of the tongue and 12% in the floor of the mouth.\(^3\) The lesions were identified by clinical observation alone, except in six cases which were confirmed by biopsy. All were asymptomatic.

These lesions, however, especially when situated in a site such as the floor of the mouth or the lateral border of the tongue, can cause diagnostic confusion.\(^3,5\) These oral sites require a high index of suspicion for any unidentified lesion, especially if such a lesion is erythematous, and biopsy may be required. When cytological scrapings have been taken in the past from such lesions, they have been erroneously interpreted as showing possible malignant change when the source of the cells were unknown.\(^6\)

With the recent revival of interest in the cytological sampling of suspicious oral lesions, it is possible that these tonsillar lesions may once more create confusion.

Microscopically, oral tonsils show a central crypt lined by stratified squamous epithelium. Peripheral to the crypt, the accessory tonsil consists of a circumscribed mass of lymphoid tissue showing normal nodal architecture.\(^1\) Immunohistochemical studies have indicated that oral tonsils are similar to the tonsils of Waldeyer’s ring in terms of their histomorphometry and distribution of Ig-containing cells. They are thought to be insignificant in their contribution to overall mucosal immunity.\(^7\)

Oral tonsils occur more frequently than is generally recognized. When inflamed, they may swell and become tender and removal may be indicated. Usually, however, oral tonsils remain asymptomatic and can be left untreated unless the diagnosis is in doubt.

**References**